STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G626	A. BUILDING _____ B. WING _____	R-C 02/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1141 19TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for a PCR (Post Certification Revisit) to the annual recertification and state licensure survey and to the investigation of complaint #IN00185576 completed on 12/31/2015. Complaint #IN00185576: Corrected. Facility Number: 001188 Provider Number: 15G626 AIM Number: 1000235380 Dates of Survey: 2/25, 2/26, and 2/29/2016. Peak Community Services, Inc. was found to be in compliance with 42 CFR, Part 483, Subpart I, and 460 IAC 9 in regard to the PCR to the annual recertification and state licensure survey and to the investigation of complaint #IN00185576. Quality Review of this report completed by #15068 on 3/7/16.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.